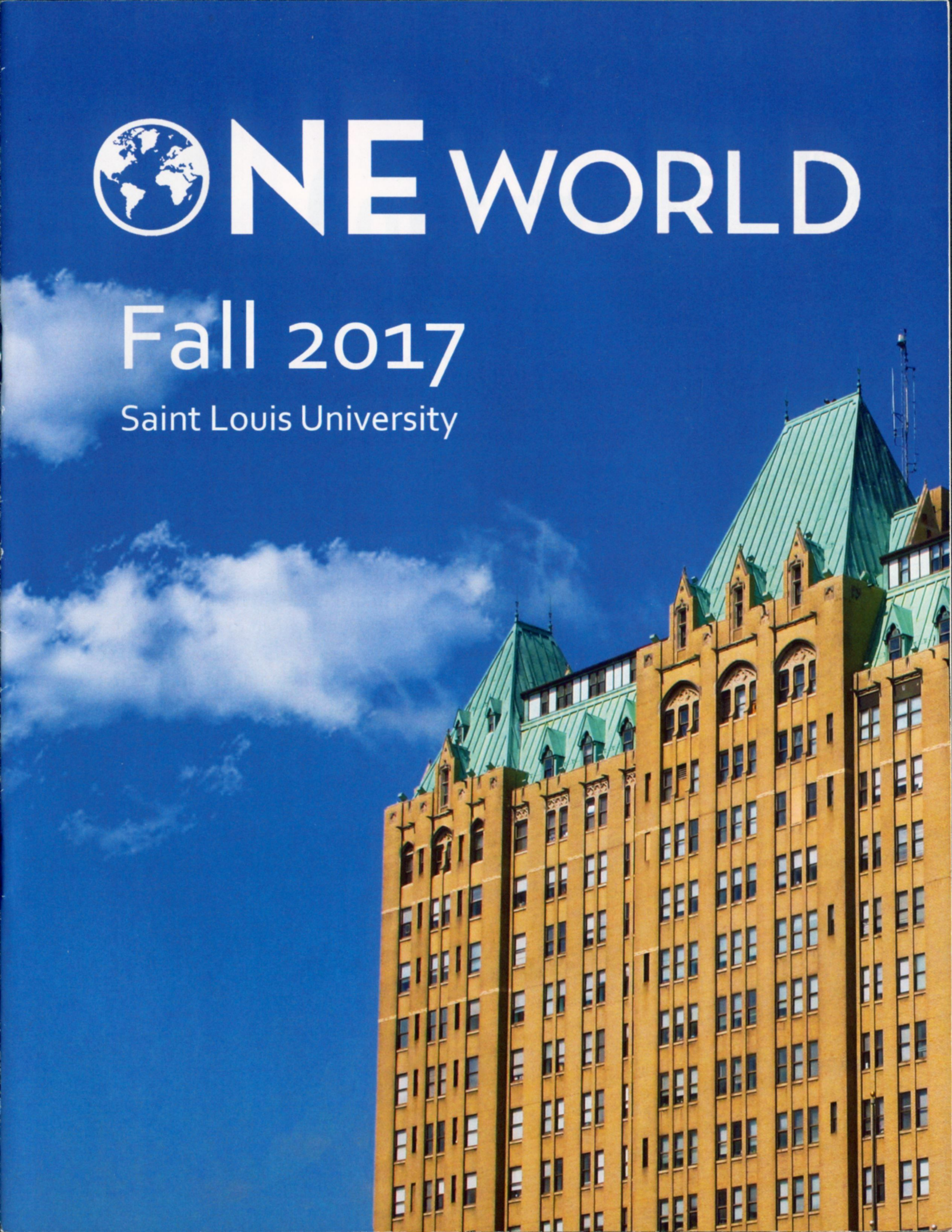
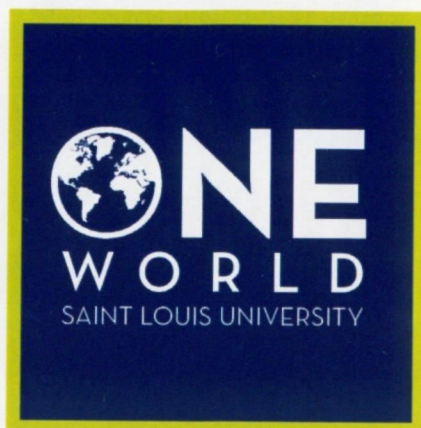




NEWORLD

Fall 2017

Saint Louis University



**Fall 2017
Volume 12
Issue 1**

Editor-in-Chief
Madeleine Hellebush

Executive Editor
Andrew D. Smith

Section Editors
Maddie Baumgart
Trevor Rogan

Copy and Content Editor
Paulina Menichiello

Design Director
Stella Jeong

Designers
Merris Barber
Rachel Hanson

Photographer
Neha Hanumanthiah

Event Coordinator
Taylor Schleisman

Event Assistant
Yesenia Sanchez

Finance Director
Trent Goencker

Promotions Director
Sam Wilson

Letter from the Editors

Dear Readers,

It is with great pleasure that we present the Fall 2017 edition of OneWorld to Saint Louis University and the St. Louis community. The American healthcare system is ever-changing, and as responsible citizens it is our job to educate ourselves on how this impacts our community, both locally and abroad.

In this issue, we focus on health care and how it affects diverse populations in our city, in our country and around the world. We encouraged our staff to learn about the struggles of our local community, such as the impacts of lead-infused water and the prevalence of food insecurity. In the United States, healthcare spending frequently dominates political discussion, leaving us unsure of its future. Internationally, we learned that political and economic insecurities lead to disparities in healthcare provided to citizens. Health care is intricately entwined in the fabric of society. We explore a wide range of topics, such as how sexual education influences both the physical and mental health of LGBTQ+ and gender non-binary students to the insufficient health care in women's prisons.

OneWorld is not simply a magazine but a call to action. We hope that these stories transform you as much as they did us. We hope that they inspire you to question, research and get involved so that we can better recognize the worth in all of our neighbors, despite the injustices in society.

"We yearn to remove the barriers of ignorance and injustice, because the most basic and unchanging truth that unites us is the infinite value of the human person."

liveOneWorld,
The Editorial Board



Contents

- 1 **One Dose Does Not Fit All:**
 Why We Need Sex-Specific Drug Research
- 3 **How Art Empowers Refugees**
- 5 **We Exist, Just Not in Sex Ed:**
 The Effect of Heteronormative Sexual Education on
 LGBTQ+ and Non-binary Individuals
- 7 **Urban & Rural:**
 Poverty and Health Care
- 9 **Health Care Culture in Latin America:**
 A Multi-Layered System
- 11 **“Lead” Astray:**
 A Quest for Facts about St. Louis Water
- 13 **Health Care for Her: Behind the Bars**
- 15 **The New Face of Hunger:**
 How the St. Louis Community Answers to Food Insecurity

One Dose Does Not Fit All:

Why We Need Sex-Specific Drug Research





Morgan Kelly

Freshman

Undecided

When a doctor prescribes a drug to you, you trust that it will help you; they are the professionals. It is natural to trust a medical professional, but if you are a woman, maybe you should think twice.

A long gender-biased history of medical research has created a knowledge gap on the effects of disease and treatments on the female body, which means that oftentimes medical research excludes women. The results are diagnoses and treatments that are not tailored to the female body.

According to Angela Ballantyne, Ph.D. of University of Otago, New Zealand, and Wendy Rogers, Ph.D. of Macquarie University, Australia, there are three main causes for the underrepresentation of women in research: protectionist policies, research ease and the perception of the male body as the medical norm.

The first, protectionist policies, is a reaction to the exploitation of groups for unethical research by the Nazis in World War II. Public outcries over the use of vulnerable groups such as Jews in medical studies led to strict medical research guidelines. While the guidelines are necessary and moral, they caused researchers to exclusively seek out non-vulnerable subjects: white, male adults.

In addition to protectionist policies, research ease and convenience contributes to the underrepresentation of women in medical studies. Recruiting diverse participants is more work for researchers, so they focus on a homogeneous research population. Women have also been left out of research because the female body has more fluctuations of hormones, which complicates research, making it more time-consuming and expensive.

The healthy male body is considered the standard in the medical community. Ballantyne and Rogers refer to this idea as “distortion paradigm,” or the thought that the male body is normal and any deviation from it—including the female body—is out of the norm. This paradigm is the final factor that causes research inequality: false assumptions about the irrelevance of sex, gender and racial differences.

The results of homogenous research groups have been devastating for females. Women metabolize drugs at a different rate than men, a fact that the medical field largely ignores. While many drug labels show different doses for body weight and age, they do not indicate doses based on the metabolization rates of both sexes. This oversight results in unanticipated side-effects for women; of the drugs removed from the market, 80 percent are a result of these reactions.

Recent calls to change research standards have

emerged. The National Institutes of Health Revitalization Act of 1993 required that studies must include women and minorities. Unfortunately, this only applies to National Institutes of Health (NIH) funded studies. Although there have been efforts like the National Institutes of Health Revitalization Act of 1993, medical understanding of the female body is still significantly behind males.

People in the field worry about the impact male-dominated research will have on medicine.

“I think the reason this has changed so slowly is because Big Pharma [the pharmaceutical industry] and the government are heavily controlled by males. They are more concerned about profits than people’s wellbeing. I see the current administration doing little to change this and even a reversal in some of the progress made,” Ron Grossmayer, a retired pharmacy manager for Walgreens and current associate professor at Midwestern University’s Chicago College of Pharmacy, said.

In 2013, Ambien, a sedative often used to treat insomnia, became the first drug for which the Food and Drug Administration (FDA) required separate male and female

“The issue should be strictly science-driven, but like so much, it is politically driven.”

standard doses. The FDA required that the recommended dosage decrease by half because women metabolize the drug much slower than men; this meant that women taking a dose before bed would wake up with it still affecting their system, causing drowsiness throughout their day. Ambien was on the market for over a decade before the FDA implemented this change.

The NIH recognizes other ramifications of excluding women from medical research. NIH records that a greater percentage of professional female athletes get concussions than males, but most concussion research focuses on male football players. This means female athletes do not receive personalized care and there is little preventative discussions around the causes of female athletes’ concussions. Similarly, organ donations to women are less successful because of the lack of knowledge of the female body’s functions.

“This issue should be strictly science-driven, but like so much, it is politically driven,” Grossmayer said.

We must take action to require the inclusion of the female body in medical research. Laws regarding medical research should follow the scientific understanding that the female and male body function differently; therefore, the female body cannot be ignored. The health of women worldwide is dependent on a change in the system. When the stakes are this high, we cannot afford to wait many years to cater to the female body. These changes need to happen now.

HOW ART EMPOWERS REFUGEES



Micah Pfotenhauer
Senior
Public Health
& Anthropology

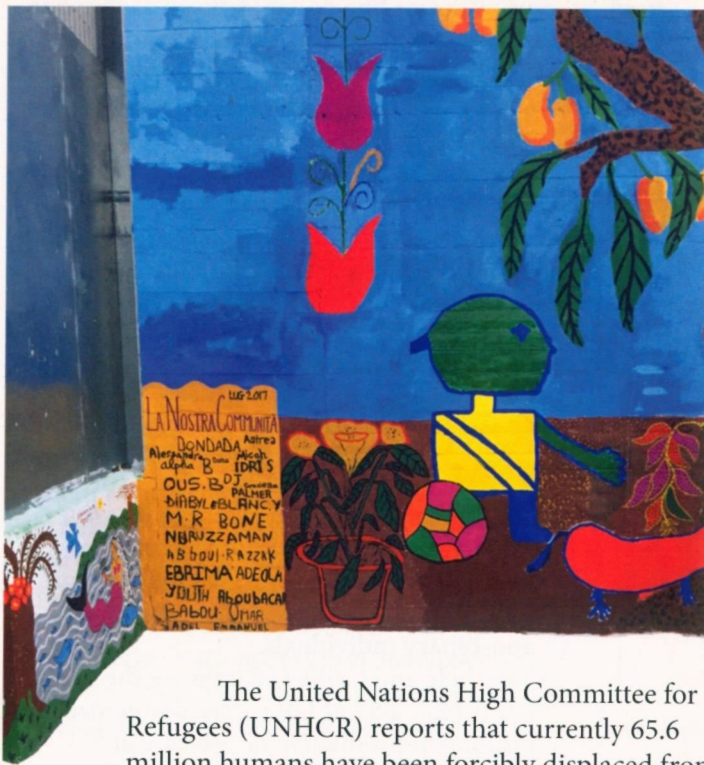
This article is based on experiences I had this past summer working at a refugee camp in Southeastern Italy. This article is not intended to speak to the needs of all refugees, nor to the nature of all host countries. My perspective is based on lived experience in one corner of the world, experiencing the refugee crisis in one of many ways.

After a bumpy, twenty-minute ride through lush tomato fields outside the Pugliese port city of Brindisi, Italy, about 200 men reside within the grey, dingy military barracks, awaiting a verdict that decides the fate of their lives. These men are asylum-seekers, uprooted from all over—North and West Africa, the Middle East and

Bangladesh—due to violence, ethnic persecution, or other severe threats. Though their situation subjects them to vulnerability and disempowerment, these men possess quiet, patient strength.

Anxiously awaiting a decision from a questionably ethical panel of immigration officials and reflecting on many harrowing memories of violence and a brutal journey across desert and sea, it is no wonder that mental health is a challenge within this community. The spirited staff works tirelessly to make the best of a broken system, yet the asylees present so many understandable needs that mental health often slips through the cracks. After fulfilling needs of physical health, bare-bones accommodations and navigation of legal red tape, offering outlets for expression or ways to process trauma are consistently relegated to the back burner. As an intern at the camp, I was able to support the staff in facilitating art workshops and a mural project to attempt to create an artistic outlet for the men at the camp.





The United Nations High Committee for Refugees (UNHCR) reports that currently 65.6 million humans have been forcibly displaced from their homes, driven by broken political systems and exacerbated by nationalism and xenophobia. With such an overwhelming amount of displaced persons in need, it can be easy to forget each of these 65.6 million people have complicated life stories, insecurities, troubles, dreams and goals.

While weaving myself into the intricate lives of the asylum seekers in Brindisi, I witnessed that support for processing trauma and mental distress understandably take a back seat to meeting needs for food, shelter and belonging in a new country. Although prioritizing mental health is difficult, paving ways for refugees to process trauma and to integrate into their new community acts as a future investment for both refugees and their host country. The overlooked power of artistic expression holds simple but effective methods to make modest progress in combatting the crisis of neglected mental health amongst refugees.

Art therapy gives a purpose to the lives of those suspended in the limbo of the asylum-seeking process. The process of art therapy can restore agency and occupy long days of waiting with fruitful activity. A proud mural painter at the CARA accommodation center for asylum seekers shared how the project impacted him.

"Before [we painted the mural], during the day we normally go and, you know, in the daytime we normally sleep. But now, all day I am here. We paint, we interact, we change ideas," he said.

The overall happiness index of the camp undeniably shifted as the men projected the art they had designed onto the grey wall of the military barracks. Deborah, a long-term member of the physiological support staff at the CARA, spoke about how she believed the art project had

transformed the camp for the men that lived there.

"For me it would be great to see these kinds of drawings and murals all over the camp. It would bring happiness and joy and something to think about, that, in my opinion could bring everyone to look forward. Even if it talks maybe about something that has happened or is a sad part of their history. But it's always their past, their culture," she said.

The mural allowed for concrete expression of the complicated emotions and mental distress that otherwise ruminates; it was an avenue to tell personal stories for oneself, not for the critical ears of asylum-granting agencies.

The UNHCR has also noticed the power of art therapy for refugees: "Through photography, painting, film or one of the many other mediums to express one's creativity, art provides a platform to raise awareness and encourages refugees to realize their own potential," Lauren Parater writes in the article "7 art initiatives that are transforming the lives of refugees."

Therapeutic self-expression holds powerful benefit in reclaiming agency for humans in all circumstances. For the very real humans, now refugees degraded to pawns in a global ideological shuffle to define rights contingent only on which side of a borderline one was born, art acts as a small rebellion against the bleakness of their situation. It contextualizes suffering, bridges cultural divides across a broad spectrum of experiences and gives volume to voices that have been unjustly muted. Art must be seriously considered as medicine in a broken world.



WE EXIST, JUST NOT IN SEX ED:

The Effect of Heteronormative Sexual Education on LGBTQ+ and Non-binary Individuals



Taylor Schleisman
Junior
Psychology & American
Studies

Hunger, thirst and sex. All basic human drives, except only one is considered taboo. Only three letters, and still such a large hold on American society: the media, pop culture and even politics. Sex is a basic, fundamental feature of human existence, so it would make sense that it would be an essential part of educating American youths, no matter their gender identity or sexual orientation, right? Unfortunately, this is often not the case, leaving psychological, physical and relational consequences where there should have been condoms and dental dams.

When it is offered, the scope of sexual education is narrow and inconsistently covers STIs and methods of contraception, relationship education and consent. What is covered, when it is covered, is aimed at cisgendered and heterosexual populations. This creates an environment where individuals who do not identify as heterosexual or cisgender do not feel affirmed or validated. They are left with an uneven education that does not always apply to their relationships or how they practice their sexuality, leaving them entirely at risk.

According to the U.S. Centers For Disease Control (CDC), around two-thirds of students will have had sex by the time they graduate high school. According to the National Conference on State Legislation, only 24 out of 50 states require sexual education as part of the public school curriculum. Yet, only 20 of those require that information to be medically and factually accurate when taught in public schools.

Political affiliation and regional influences within state governments can greatly affect the curriculum of sexual education in a state. States like Colorado and California, with traditionally liberal state governments, tend to favor comprehensive and age-appropriate sexual education. Several states with traditionally conservative state governments, like Missouri and Tennessee, tend to favor the promotion of abstinence education and family planning over comprehensive contraceptive education in public schools. Some states, namely Alabama, Arizona, Louisiana, Mississippi, Oklahoma, South Carolina and Texas, even go so far as to imple-

ment what they call “no homo promo” laws and programs. According to the Gay, Lesbian and Straight Education Network, these are: “local or state education laws that expressly forbid teachers from discussing gay and transgender issues (including sexual health and HIV/AIDS awareness) in a positive light—if at all.” This creates a hostile environment for these students and promotes discriminatory treatment of LGBTQ+ and non-binary individuals.

Amanda Buechele and Callie Calamia are the founders of ‘Healthy is Hot’, a Saint Louis-based organization that aims to promote reproductive health care at SLU and the surrounding community. Having experienced the frustrating bureaucracy of SLU firsthand when it comes to equal representation on campus, they decided to take matters into their own hands.

“When it comes to policy and decisions being made about sex ed and queer inclusiveness in schools, kids are often just the pawns of adults’ political games. It’s so much of ‘I believe this’ and ‘I believe this,’ and ‘this is why we can’t do this.’ And that’s fine, but this is not about you, this is about the kids in these schools who need to be educated according to their sexual wellness and their sexuality,” Calamia said.

Rather than simply encouraging abstinence, all students, regardless of sexual orientation or gender identity, need to be taught the tools to protect themselves and their partners in order to practice safe sex.

Buechele proposed a way to ensure that both abstinence and contraceptive education reach youth.

“In the umbrella of sex ed decisions, [abstinence] definitely belongs there, but it should ... be taught in the proportion that it is practiced in a community,” Buechele said.

For example, if two-thirds of the high school population are sexually active, then two-thirds of their sexual education should be comprised of contraceptive-based teaching.

Even though one in every 10 people identifies along the LGBTQ+ spectrum, the reality is that, according to a 2015 Human Rights Campaign (HRC) survey, only 12 percent reported that same-sex relationships had been covered in their sexual education course. Of those who reported that same-sex relationships had been covered, less than 5 percent of those who identified as LGBTQ+ felt that they were portrayed in a positive way.

These statistics are important to consider because LGBTQ+ and non-binary individuals have a somewhat unique experience. Unlike other minority groups, they also

experience discrimination and rejection from within their family units and close friends because of how they identify; this creates a situation where being authentically one's self is not acceptable within the setting where one should feel most comfortable. This feeling can permeate into sexual education classes, where certain sexual and gender identities are not only unacceptable, but not even worth acknowledging.

These feelings of uncertainty and insufficiency can take an extreme psychological toll on those questioning or coming to terms with their sexual orientation or gender identity. These individuals often struggle to understand and accept themselves, while also dealing with external relationships and the reception of others. According to the *Psychiatric Times*, it is not uncommon for someone in these types of situations to experience dissociation between their external persona and their sexuality, low self-esteem and self hatred, depression and withdrawal, suicidal thoughts and substance abuse issues. Most of these problems result from structural and cultural expectations that oppress, exclude and discriminate against non-heterosexual and non-gender conforming individuals, which are perpetuated through exclusive sexual education programs.

According to the National Sexuality Education Standards issued by the U.S. Department of Education, "Two-thirds of LGBT students reported feeling unsafe and nearly one-third skipped at least one day of school because of concerns about their personal safety." Schools and their classrooms should be safe spaces for all students, especially those in distress or those being targeted. These unwelcome environments cause LGBTQ+ and non-binary individuals unnecessary additional stress; implementing an inclusive sexual education curriculum could lessen the negative psychological effects that LGBTQ+ and non-binary individuals experience.

According to the CDC, 50 percent of STIs are contracted by people aged 15-24, a group that represents only 25 percent of the sexually active population. The rate of STI incidence has increased steadily since 2012, yet there has been no motion to mandate comprehensive sexual education in primary and secondary school settings for public schools, let alone private institutions. At the same time, while rates of teen pregnancy are on the decline, studies show that LGBTQ+ individuals are twice as likely to be pregnant or have gotten someone pregnant. This is a clear indicator that the sexual health of young people--especially LGBTQ+ youth--is not being prioritized in America.

If LGBTQ+ youth are taught about STIs and contraception only through a heteronormative lens, they may assume that they are not facing those same risks in non-heterosexual relationships. Also, the stress of identifying as non-heterosexual or non-binary may cause individuals to act more recklessly in an effort to gain acceptance from their peers. Currently, LGBTQ+ youth are often forced to search the internet for viable, inclusive sexual education and feelings of acceptance. While some of this internet content is effectively educational, it may also perpetuate negative stereotypes and medically inaccurate information.

The danger of heteronormativity in sexual education goes further than ignorance of STI transmission and

safe sex practices. Primary and secondary education settings often neglect to teach students about positive relationship practices. Knowing what a healthy and consenting relationship should be a vital part of sexual education curriculum. However, many people remain unaware that consent is required, even while in a relationship, for any sex-related act. Consent is defined as verbal affirmation and is considered void if one or all parties are under the influence of drugs or alcohol at the time. This should be made clear to students before they are ever in this kind of situation.

Students need to be taught to recognize signs of abuse. It is also important to emphasize that it can also occur in non-heterosexual relationships. Curriculums should be aware of the language of these conversations and how it reaches LGBTQ+ and non-binary individuals. According to the HRC, "Bisexual women are at particularly heightened risk, with 61 percent of bisexual women experiencing rape, physical violence or stalking by an intimate partner, compared to 44 percent of lesbians and 35 percent of heterosexual women." Most resources for identifying signs or finding help use heteronormative pronouns and scenarios, isolating those in non-heterosexual relationships.

The National Sexual Education Standards offers a fairly comprehensive curriculum that proves that these concepts are not revolutionary by nature. While it is not perfect, it is a good start. By revising this existing curriculum to be more inclusive and mandating it in schools at a federal level before individuals become sexually active, students, especially LGBTQ+ and non-binary conforming students, could decrease their risks for psychological, physical and relational issues when they do choose to become sexually active.

A solid first step could be as simple as not assuming heteronormativity in class settings and using gender neutral pronouns. While this may be difficult in areas where religious or conservative values seem to outweigh the health concerns of our youth, at a certain point they must accept that medically and factually accurate information includes LGBTQ+ and non-binary individuals.

If this concept proves too contrary to individuals' or institutions' morals, there are other solutions. As Healthy is Hot's Amanda Buchele points out, "If you have an entire school in Indiana and every single teacher says, 'I will not support sex ed', there's a Planned Parenthood in every state that can come in and do sex ed. There are other options where you don't have to have your specific employee be giving sex ed for schools if they're not comfortable."

Sexual education needs to be a safe space to ask questions and explore different forms of sexual orientation and gender identity expression. Students should be able to get a comprehensive idea of their bodies and how they work. They should learn what sex is, how to practice all forms of it safely and how to engage in healthy and consenting relationships, no matter what they look like. None of this should be limited by how one identifies. People are not political pawns, and sex is human. Not properly educating all individuals is an incredible public health risk, end of story.

URBAN & RURAL

POVERTY AND HEALTH CARE



Nish Gorczyca
Senior
Communication

Healthcare coverage is one of the most divisive issues facing the United States today, and outcomes especially affect the most vulnerable populations. The cyclical relationship between illness and poverty is one that affects those who reside in both rural and urban areas of the United States. These effects vary due to the unique challenges that each environment poses to the people living in it.

"We have a system that provides treatment for everyone, but if you're poor, we only treat you in emergencies; we don't treat you in long-term and thoughtful contexts," said Dr. Timothy Huffman of the Saint Louis University Communication Department; he also mentors the Labre ministry that aims for relationship-based outreach for the homeless population in St. Louis.

Cities pose many health risks for its citizens, especially those living in poverty. Occupational hazards, poor living conditions that lead to disease outbreaks, poor nutrition and lack of access are just a few of the issues affecting the urban poor, according to the World Health Organization (WHO).

According to the WHO's 2010 World Day Report on urban poverty, "Access to services for the urban poor may be limited by ability to pay, even in the context free health services where medications and supplies are not free, location or hours of operation is inconvenient, and care is of

poor quality."

"Access to healthcare is a serious problem," Dr. Donald Stump said, director of the Micah program at Saint Louis University. "A lot of people who might be eligible for Medicaid are probably not plugged into the system enough to know they can get Medicaid."

"The sheer physical access...there just aren't many clinics or hospitals available," Stump said. "It's very tricky to set up a pro bono outreach clinic to give, for example, early childhood vaccinations or prenatal care, or even just to do blood tests for cholesterol because the legal possibilities of a lawsuit really pose a danger."

"We have a system that provides treatment for everyone, but if you're poor, we only treat you in emergencies; we don't treat you in long-term and thoughtful contexts"

Those who need healthcare face barriers because of complicated access, which results in infrequent use. In addition, there are difficulties in providing care for those who have trouble paying for services.

On the other hand, rural areas are much more expansive than cities, and getting to a medical facility can be detrimental to one's health in and of itself. For individuals in rural areas, the issue goes beyond ability to pay; the

medical workforce is simply not large enough to serve the population's needs. Similarly, the rural poor find access to proper healthcare difficult. The National Rural Health Association reports that rural areas only have an average of 39.8 primary care physicians per 100,000 residents, compared to an average of 53.3 primary care physicians to 100,000 residents in cities.

"If you're poor in the city, you're space poor; and if you're poor in the country, you're service poor."

"If you're poor in the city, you're space poor; and if you're poor in the country, you're service poor," Huffman said. He also notes the difference in healthcare for the poor; rather than focusing on preventative treatment, emergency treatment and symptom management are generally the focus. "In the city, you drive around and the billboards are for hospitals. In the country, you drive around and they're for pain specialists."

The suffering of poverty is revealed in emergency rooms because preventative healthcare measures are costly. On the other hand, poor health can exacerbate poverty, especially given that poor people frequently cannot afford health insurance. The cyclical relationship between the two creates difficulties for both the rural and urban poor alike.

"If you have a massive healthcare crisis that causes you to lose your job, and then you lose your healthcare because you lost your job, you might become homeless because you become impoverished because of your healthcare," said Huffman. "So it works one way, but it works the other way, too. Being homeless is super hard on your body, and the way that we respond to it is in a nutritionally deficient way."

The healthcare issues facing the poverty-stricken populations in the United States also go beyond the ability to pay and to reach the providers. Access to proper nutrition is fundamental to good health, and both urban and rural residents face challenges when trying to adequately nourish themselves.

According to the WHO, "Urban poor populations in the developed and developing world often rely on street food, fast food, processed and cheap food, leading to nutritional problems such as vitamin/mineral deficiencies, dental problems and obesity, which in turn is associated with diabetes and cardiovascular problems." These foods are known for their addictive qualities, and fast food companies knowingly exploit poor populations to increase sales.

"It's hard to be poor, and that kind of environment leads to a nutritionally compromised diet because people who are stressed choose foods that are good now and not in the long run," Huffman said. "I have this suspicion

that highly addictive foods are more competitive in highly impoverished markets because the addiction drives their consumption over other things that people don't have very much money to spend on."

Rural populations face different challenges in regards to proper nutrition, as they can struggle with obtaining sufficient amounts of food. The distance between residences and grocery stores can make it difficult to purchase enough food, especially if one lacks a reliable form of transportation.

Like in urban areas, the lack of access to proper nutrition is linked to heart disease, diabetes and obesity, as well as all health issues associated with these conditions that may be expensive to treat. RHIhub reports that 20.4 percent of rural families with children do not have access to enough food, as opposed to the national average of 16.5 percent of all households with children.

On a national level, improvement to the system is difficult because it requires completely overhauling the healthcare legislation to be more inclusive of all society. "The belief that you can make it if you try in America is the greatest barrier to healthcare for all," Huffman said.

On a more local level, there are more personal ways to change the status quo, like simply interacting with those who need the help. "Start with knowing people, and keep knowing them until you hear something that haunts your dreams," Huffman said. "Then you become an activist."



HEALTH CARE CULTURE IN LATIN AMERICA

A Multi-Layered System



Suzy Kickham
Sophomore
Philosophy

The age-old question: should healthcare be private or public? Though it seems like a simple answer, it actually contains a multitude of layers. When peeled back, it is clear that a proper standard of health for all should not and need not be compromised.

Many believe that if health care is privatized, even if by charitable organizations, only some will have access to it; on the other hand, if healthcare is expanded to everyone, its quality is called into question. Although the health care predicament is a global phenomenon, it is especially salient in Latin America. This summer, I had the opportunity to visit the Casa Materna in Matagalpa, Nicaragua, which has been a key component to the reduction of the maternal death rate in the country for decades. Casa's website explains that it: "provides a short-term residence in the city of Matagalpa, offering food, shelter, education, transportation and support for high-risk pregnant women before and after childbirth." This facility was intentionally placed in an area that offers easy access to women in rural areas--those most vulnerable to maternal and infant death. They receive funding mostly from charitable organizations, such as Friends of Casa Materna, which is based in the United States. Since its founding in 1991, the Casa has cared for and even saved just short of 18,000 lives--half of those being newborn children. According to UNICEF, the infant mortality rate in Nicaragua is 22 per 1,000 live births, more than double the rate in the United States. This is no easy problem to address.

In recent months, Nicaragua's Ministry of Health (MINSA) has decided to provide maternal and natal care to women in the region. This means that the government would establish a multitude of "Casa Maternas" throughout the country and essentially shut down the Casa in

Matagalpa. As a result, medical care for women and their newborns would expand widely and more attention would be given to an issue that has posed a serious threat to the nation for too long.

As it is only one organization, the Casa in Matagalpa cannot support the needs of Nicaragua's entire maternal and infant population. Casa Materna's employees viewed the governmental expansion as a positive, but they expressed concerns about the quality of healthcare the government would be able to provide. They fear that the service to each individual will be less personal and holistic, as they foresee the worker-to-clientele ratio being highly disproportionate.

This issue in Nicaragua demonstrates the potential pros and cons of government-funded versus private charity-funded health care. Though the country is moving in the right direction in terms of allowing everyone basic access to health care, a danger is that this mentality might lead the government to only seek checking off boxes and filling quota. At face value, the number increase is positive, but the layers underneath must be addressed.

Ideally, everyone would have access to high quality health care. Clearly, this is no simple task. Does an increase in quantity necessarily mean a decrease in quality?

Living a full life requires navigating the healthcare system successfully. Health care as a whole is integral to the quality and longevity of one's life, and is even considered a basic right in Article 25 of the United Nation's Universal Declaration of Human Rights. It determines so much of an individual's livelihood; inaccessibility to a fair standard of health services can result in long-range physical, mental, emotional and financial debilitations for the individual. Ac-

cording to the World Health Organization, good health care benefits both the individual served and society as a whole: "It also makes an important contribution to economic progress, as healthy populations live longer, are more productive, and save more."

In Nicaragua, every citizen is afforded access to at least some basic-level medical care, but who provides that care, either private or public entities, and thus the quantity and quality of it, varies. In Brazil, however, proper health-care is a constitutional right for all its residents. Therefore, the government established the Unified Health System (SUS), which receives the majority of its funding from taxes.

Most citizens are covered by the public SUS, but the richest 25 percent of individuals use private healthcare. Everyone in the country is protected by SUS, which offers substantial primary-care resources. Though Brazil has made significant quantitative bounds in the health realm, the quality of care requires much improvement. This contrasts with the private-charity situation brought upon by the Casa Materna in Nicaragua, taking the form of the government-funded Casa program, though encompassing a wider range than maternal care.

So what is the best way to take on the complicated beast that is health care? Is a choice between quantity or quality required?

"Not necessarily," said Dr. JD Bowen, a Political

Science professor at Saint Louis University and an expert in social, political, and economic issues in Latin American countries. "Again, it comes back to resources and if you take the same amount of resources and double the amount of people it covers you're probably going to reduce quality. But where you've seen huge improvements in the past couple of decades is in primary care where with relatively few resources you can expand coverage."

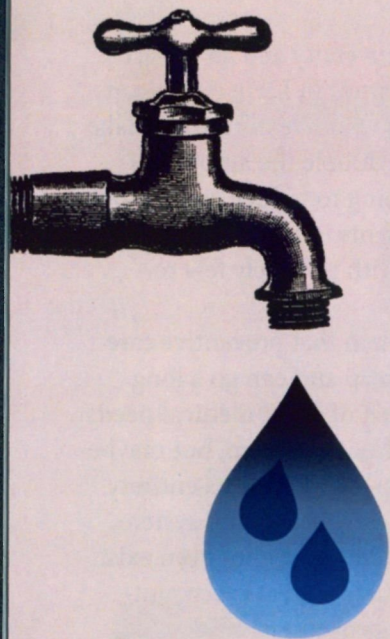
Dr. Bowen went on to explain that preventive care and care for youth are relatively cheap and can go a long way. Of course, there are a large host of other medical needs that must be addressed by the healthcare system, but maybe the approach need not be an "either-or" deal in its entirety.

Although there are pros to any healthcare system, the ideal one has yet to be implemented; it may not even exist. With any system, though, there must be greater accountability in the maximization and improvement of service.

It is crucial to increase the quality of aid as well—which may not increase the cost as much as people typically assume. Only in this way can society have something to rejoice in with the closing of charitable organizations like Casa; if this were pursued, those near 18,000 helped could rise to twice, three, potentially even more times that amount. Thus, uncovering and addressing these complex layers of health care could lead us to the core of it, which is to enhance the quality of life for all.



mural inside the Casa



“Lead” Astray:

A Quest for Facts about St. Louis Water



Maddie Baumgart
Junior
International Studies
& Sociology

What we don't know *can* hurt us. Ask the unsuspecting protagonist of any horror movie. Or, ask anyone unknowingly poisoning themselves through drinking lead-contaminated water. As it turns out, you might not need to look far. If you live in St. Louis, you may know less than you think about your water's quality.

Lead is a powerful neurotoxin, the effects of which prove irreparable. After ingestion or inhalation, a majority of the poisonous substance is stored alongside calcium in bones, awaiting its release years later during puberty, pregnancy, old age or any other period when the body might mobilize these calcium reserves. In essence, it is the Trojan Horse of toxins.

High levels of lead exposure can lead to death or mental deterioration, but even low levels can cause a host of problems, ranging from lowered IQs, aggressive behavior and premature births to stunted growth and an increased risk of cancer and cardiovascular disease. While lead poses a danger to any age group, children and pregnant women are especially vulnerable; their bodies both absorb more lead and draw upon more calcium.

In St. Louis, conversations about lead poisoning tend to glance off lead pipes and find purchase on lead paint. While lead paint remains a problem more than three decades after civil rights activist Ivory Perry agitated to pass legislation banning it, several lead paint remediation efforts exist in the city. Although paint is usually regarded as the predominant source of lead poisoning, the Center for Disease Control cites water as the primary source of 30 percent of lead poisoning cases—and up to 60 percent of cases that concern formula-fed infants.

A cynic might suggest one clear reason to divert attention away from the issue of lead in the water: aversion of responsibility. Whereas lead pipes land in a murky in-between of responsibility, lead paint falls cleanly into the domain of the homeowner. Public outcries following the water crises in D.C. and Flint have inspired city officials to adopt a defensive stance, one that often suppresses awareness of the issue.

This stance characterizes St. Louis' efforts: last year the Water Division claimed that the water “far exceeds state and federal regulations.” The director, Curt Skouby, reassured public radio listeners that “Flint's problem is not our problem,” because the city treats its water to ensure it is not corrosive.

“Only if the water were corrosive could lead be picked up by the water,” the Water Division said.

To an extent, these claims are true. St. Louis does not

use lead pipes for their mainlines, so any lead originates from the service lines (which lead to the building from the mainline) or from lead in plumbing fixtures or solder between pipes. The city does, in fact, treat the water to ensure its non-corrosivity. However, according to the St. Louis Dispatch, 88 schools had elevated levels of lead in their water in 2016—16 of which far exceeded the concentrations commonly found in homes in Flint.

Something doesn't add up.

While St. Louis has indeed met federal guidelines for water, further investigation reveals those guidelines are remarkably shabby and fraught with skewed sampling techniques. Though no amount of lead is considered safe, the EPA defines 15 parts per billion (ppb) as the benchmark at which cities are legally required to take action—despite the fact that even one-fifth of this amount can cause developmental delays in children. The EPA requires 90 percent of homes to fall within this range; because St. Louis is on a “reduced compliance plan,” the city must test only *one* tap at 50 houses every *three* years.

Paul Schwartz, co-founder of the Campaign for Lead Free Water, an organization dedicated to empowering water consumers to challenge federal regulations and demand inclusion in the decision-making process, dubbed these tests a “meaningless attempt at false reassurance.”

For one, the nature of lead renders a single test arbitrary. Lead can be dissolved in water or be present in particle form. Treating water to reduce its corrosivity prevents lead pipes from dissolving but does nothing to address lead particles—dislodged because of stagnation, outside temperature, hot water use or physical disturbance like roadwork—from traveling through the tap. The likelihood of “catching” that particle during a single test of a single tap proves unbelievably slim.

Determining the risk of lead poisoning requires dozens of such tests. In fact, a recent American Water Works Association study showed that if the sampling protocol was actually designed to detect these particles, nearly 75 percent of homes in the U.S. with lead service lines would legally require immediate action. As a leading activist during the D.C. water crisis, Schwartz points

out another issue embedded in the law: it legally permits the water in 10 percent of homes to have any lead concentration whatsoever.

"In D.C. there were homes in the 100,000 ppb range that were in all technicality in compliance with the EPA's law, because there were other homes that tested below 15 ppb," Schwartz said.

Billikens for Clean Water (B4CW), a SLU organization committed to addressing global and local water-justice issues, found further flaws with sampling methods. Investigation into the St. Louis water crisis revealed that African Americans are over twice as likely to suffer lead poisoning than white residents. Minority students constituted over 85 percent of the student body at many of the schools with the highest concentrations of lead. Still, the city conducted the vast majority of tests—90 percent—in South St. Louis rather than North St. Louis.

B4CW is not alone in the conclusion that race and poverty impact the severity of the lead issue. The demographic breakdown of the schools affected by lead inspired the Washington Post article entitled, "In St. Louis schools, water fountains are symbols of inequality again."

Still, the city has been unwilling to acknowledge this inequity. Skouby, Director of Public Utilities, cited cases of lead poisoning in the upper- to middle-class, primarily white Ladue suburb to demonstrate that the problem had no racial or class dimension. B4CW, however, found not a single elevated lead test in the area. Deflecting questions about the role of race and class fails to inform low-income, minority families that they might be at a heightened risk.

Of course, this is not surprising: the city ignores any risk in the first place. According to the Dispatch, at least 3,300 St. Louis children have lead in their bloodstream, but when city authorities investigate the cause, they only test the paint in the children's homes.

Acknowledging lead-tainted water as a problem raises the question of who is responsible for remedying it.

A primal impulse urges one to drop the issue in the lap of those inexorably responsible: in this case, the Lead Industries Association (LIA). Well into the 1970s, the organization lobbied local, state and federal governments to require lead service lines *by law* and passed on "educational" materials celebrating the health benefits of lead to those responsible for water distribution systems. Published proof of the dangers of lead was abundant by the 1880s, according to Dr. Yanna Lambrinidou of Virginia Tech.

Slow-adapting federal regulations also could bear some blame. In 1986, Congress passed the Lead Ban, limiting pipe and pipefittings to eight percent lead by weight, at which point they were branded as "lead-free." In 2014, the permitted amount changed to 0.25 percent; however, these supposed lead-free taps can still dispense high levels of lead. Shockingly, according to both Lambrinidou and Schwartz, lead is added to plumbing materials even to this day.

Legally, however, the bulk of the burden for remedying the lead situation lands on consumers—those who did not choose the composition of their service line nor possess any record of it. In St. Louis, homeowners or landlords technically own the service lines. The original Safe Drinking Water Act mandated that cities foot the bill for pipes that went into privately owned homes, but in 2000, this was revised to shift the cost and responsibility to the homeowners.

Though much of ensuring safe drinking water currently remains the obligation of water consumers, St. Louis officials neglect to inform individuals they might be at risk, opting instead to pacify them with claims of the water's supposed high quality.

"It's like a bus is speeding down the road, invisible. The

bus isn't going to stop, and the people are expected to avoid it," Schwartz said.

Still, he believes that such a task is possible.

"We just have to ask the right questions, demand accountability and expose lies. Never doubt the difference one person can make."

You can justifiably see the glass half-empty and blame governmental neglect. Or, you can adopt the posture of Schwartz and see the glass half-full and an opportunity to rewire the system to a more democratic structure. Whatever your preference, it is time to figure out exactly what is in that glass.

Brain:
ADHD, lowered IQ,
behavioral disorders,
learning disabilities,
memory loss

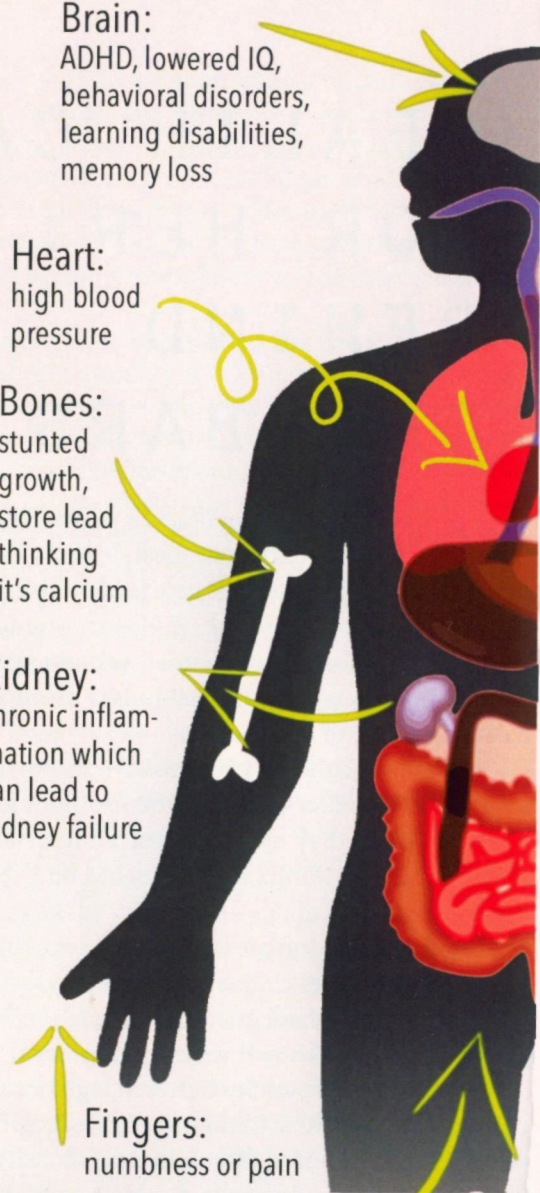
Heart:
high blood
pressure

Bones:
stunted
growth,
store lead
thinking
it's calcium

Kidney:
chronic inflam-
mation which
can lead to
kidney failure

Fingers:
numbness or pain

Reproductive System:
damage sperm, also can be stored in
bones and released when pregnant,
harming fetus.



HEALTH CARE FOR HER: BEHIND THE BARS



Beatrice Beirne
Freshman
Political Science &
Criminal Justice

Orange is the New Black, a pioneering Netflix Original about the cutthroat lifestyle in a women's prison, captured audiences' hearts after airing its fifth season this year. The thrill-driven drama opens conversations about race, gender, sex and sexuality, poverty and the misogyny that pulses through the basic discourse of our society.

When culturally progressive shows like *Orange is the New Black* redirect the spotlight to initiate a conversation, they inevitably leave important truths in the dark. The Netflix series touches on— but has done little to articulate— the reality of life in women's prisons for actual inmates; instead, it sexualizes plot-lines and marinates characters in sassy retorts and humor. The lack of adequate healthcare for women in prison, however, is a real issue inmates must face.

The discrepancies between legislated women's correctional healthcare and its actual execution dictate the basic standard of quality and security of our prisons as a whole. When it comes to women's health care in prisons, *Orange* leaves us in the black.

The necessity of prison healthcare reform is drastic and undeniable, as it impacts over 2.1 million currently incarcerated Americans, with women composing a detectable minority at 9.7 percent, according to PrisonStudies.org.

Women in prison are the perfect storm of misfortune. They have more serious health problems and needs than men (often reproductive and pregnancy-related); are more frequently victims of rape, domestic violence, assault and child abuse (up to 90 percent experience this abuse before entering prison and innumerable experience after entering); have higher rates of addiction; and are more likely to experience intense psychological trauma than men. These studies have been confirmed time and time again by US National Library of Medicine, Drug Policy Alliance, ACLU, Bureau of Justice Statistics, and Women's Health Care in Correctional Settings.

Women in prison often find insufficient health care inescapable—in both its quality and administration. According to the National Commission

on Correctional Health Care (NCCHC), the basic health care for women in prison revolves around gynecology and STD care; pregnancy and postpartum counseling; parenting, family planning and child care; menstruation and menopause; nutrition and diet; mental health and medicine; and sexual, physical and substance abuse. However, the NCCHC found that every single one of these domains is met inadequately, with little respect for the dignity of female inmates or the urgency of their needs.

Initiative to correct these discrepancies and alleviate these wrongs is stunted for two reasons. The comparably small population of women inmates and the higher expense of their healthcare proves unattractive for solution-seeking politicians, and correctional health care—like any vector of criminal justice—suffers from severe budgetary deficits and a lack of enforcement accountability. When women are incapable of obtaining appropriate and effective healthcare on Capitol Hill, it comes as no surprise that fair and basic healthcare is almost an impossibility behind bars.

Malpractice in health care can be as minute as failing to ensure that inmates take their medicine, to as intrusive as pressuring sterilization. Many of the discrepancies between policy and practice arise in inmate reproductive care. Aside from routinely receiving gynocare from unqualified, illegal and unaccommodating doctors, women in prison are forced to choose between long-term and short-term discomfort.

"Most people choose not to get pap smears because these experiences are painful. You want to deal with medical as little as possible because they hurt you," said a former inmate in a 2015 Truth-out.org article.

Even when they do attend appointments, pathetically outdated and violently unsafe tactics are implemented. In prenatal and pregnancy operations, basic access to antibiotics is often sacrificed for cost, without regard for the mother's health: In a 2013 Al Jazeera article, former inmate Regan Clarine recalls



sugar packets and gauze being used to treat cesarean scars for post-childbirth women.

This assertion is not unfounded; countless inmates have shared their testimonies online, from refusal of antibiotics to forced formula-feeding of children. Women with Irritable Bowel Syndrome and similar conditions have no secure access to amenities or protections and are forced to suffer through the ridicule and pain that ensues. Most shockingly, cancer patients can be bluntly denied a doctor's appointment or radiation therapy, as some prisons have formally stated they cannot "guarantee transportation to appointments, [and] that the correctional officers could cancel for any reason" according to The Virginian-Pilot.

Health care malpractice in prisons, however, is only an effect of something much larger. The climbing prison rate of the nation as a whole has procured several destructive, cyclical atrocities. The inappropriate imprisonment of the mentally ill, the vicious weaponization of bail and mandatory minimums, utter disregard for trans identification, irrational enforcement of municipal violations, the slaughtering of black and brown bodies, heartless seizure of parents from families and the reckless privatization of prisons are all products and perpetuations of an increasing incarceration rate. Though the number of imprisoned women appears to be small, the extent to which their internment destructs society is immense, which can be exemplified through the mothers behind bars.

In the early 2000s, genfkd.org found 61.7 percent of women in state prisons were mothers and 52 percent were the family's sole breadwinners. These women lack proper healthcare, prenatal and maternity care and childcare. Thirty-eight percent are deprived of proper connections with their children (which frequently permits the state to put the child up for adoption), according to the Bureau of Justice Statistics.

When dissecting prisons in any capacity, it is essential to acknowledge the role that race plays in the creation and execution of legislation.

In her book *Invisible No More*, Andrea Ritchie alludes to familiar narratives of bias and how, unsurprisingly, the racial imbalance of incarceration rates in men is similarly and systematically embedded in the incarceration of women.

"The war on drugs has become a largely unannounced war on women, particularly women of color," Ritchie says.

And this is true: since 1980, the number of women behind bars has skyrocketed over 700 percent, according to The Sentencing Project. While white women are five and

three times more likely to use marijuana and cocaine than women of color, respectively, African-American women are more than three times as likely to be incarcerated, and Hispanic women are 69 percent more likely according to a ACLU report and the Drug Policy Alliance. While unjustified incarceration of anyone is erroneous, a clear divergence from systematic racism is essential for its eventual correction.

The key to prison reform is in the name: we must liberate the cruel and unusual punishments women inmates are subjected to and prevent maladministration of improper health care from consuming our nation. The transition of the health care system will be hard, but not impossible; examples of idyllic success can be seen in the aspirations of addiction healthcare and, since roughly 80 percent of women behind bars suffer from addiction, it is worthwhile to dissect how care is being handled (genfkd.org). Rest assured, the way our law enforcement and legislation currently deals with addiction is anything but perfect, yet its new ways of prevention and decriminalization are pioneering the age of appropriate national correctional health care.

Former director of the National Drug Control Policy Michael Botticelli emphasizes that a toxic stigma against addicts—or women in prison, for that matter—can harm everyone, and altering our perceptions can lead to a safer, more productive society. Three simple points are necessary to altering the stigma of addiction. For existing inmates, the government must provide treatment, not jail, and legislate liberty that holds law enforcement and private prisons accountable for poorly administered care. Students and inmates alike must have access to education, including information on proper self-care, in order to nurture a safe society full of informed and capable individuals.

When applied to women inmates of all gender identities, these three pillars are capable of not only changing the gross injustices occurring behind bars, but opening up the possibility of a transcontinental decrease in mass incarceration and significant increase in the national standard of living.

As the famed Fannie Lou Hamer saying goes, "Nobody's free until everybody's free." This is true; a blanketing approach to imprisonment and correctional healthcare poses a grave threat to the liberties of those on both sides of the bar. *Orange is the New Black* earns its praise for generating important conversations about race, sex and power, but when it comes to the women in orange, it really is time we all unpack.

The New Face of HUNGER

*How the St. Louis Community
Answers to Food Insecurity*



Suraj Marwaha
Junior
English

Fill in the blanks: An _____ a day keeps the doctor away. Eating _____ improves eyesight. Drinking _____ builds strong bones.

If you answered “apple,” “carrots” and “milk,” then you, like many Americans, have devoured iconic, idiomatic adages that speak to the all-American, Urban Dictionary definition of a healthy diet. But, as scientific literature suggests, such phrases hold truth: the antioxidants and fiber from apples reduces risk of cancer, diabetes and heart disease; beta-carotene from carrots generates vitamin A, a barrier to blindness; and, though the nutritional value of milk has not avoided the eye of skepticism, calcium is scientifically seen to restore skeletal health.

Americans have an intuition as to what is healthy and what is not. And yet, nearly 17 percent of Missouri households were food insecure in 2016, compared with 14 percent nationwide, placing it among the top 10 worst states concerning food security. If the community knows what is right—even intuitively—then why are they unable to do what is right, to make healthy dietary choices? In other words, what accounts for the high rate of food insecurity across the US, and in particular, Missouri?

Food insecurity is often used interchangeably with hunger, but there is indeed a distinction. Hunger is a physiological state that ranges on a spectrum of pain, spanning from one’s longing during a diet, to the more serious starvation. Food insecurity occurs when a family or individual is unable to obtain adequate food—the right food, healthy food—or acquire it in a socially acceptable manner. One can be perfectly full but be food insecure.

At Doorways Housing, a transitional facility that strives to rebuild those left homeless due to HIV and AIDS, many residents may be full, but are indeed food insecure.

“Their daily diets consist of comfort food: high starch, high carb foods. When they’re full, they’re complacent. They’re less likely to start fights with housemates, and they’re generally far more peaceful,” Patrick Young, a volunteer coordinator for Doorways, said. “We strive to create a peaceful environment, as their lives in their proper homes were far from that.”

The housing facility also coordinates many off-grounds events, such as trips to the Golden Corral, where customers have free-reign over a variety of fried delicacies—chicken fried steak, teriyaki beef, cajun sausage, tuna bacon melts. The only “green” food item served is creamed spinach.

“We save up our money, sit at the Corral for three hours, and eat, eat, eat,” said Ryan W., one of the residents of Doorways. “And we eat until we can eat no more.”

To answer this growing need for healthy food options, a group of women established CityGreens in 2008. The “Midtown Mamas” began addressing the difficulty of getting to the nearest grocery stores and noticed how expensive the food was, even though it was not organic. After laying stake in an economically depressed urban environment, they saw that their culinary tradition was faltering: there was a lack of availability of produce and instead an abundance of cheap, unhealthy, junk food; the presence of fast food restaurants and Golden Corrals popping up on nearly every street corner compounded the issue.

“We saw the obvious link between the high rate of health problems in our community and the lack of healthy food options,” Resenda Sykes, founder of CityGreens, said. “So we organized a community supported agricultural [CSA] program with Gateway Greening.”

Though a trip to the Golden Corral might not leave Ryan and his housemates hungry, it certainly leaves them food insecure—devoid of their alphabet of essential vitamins and minerals. Consuming upwards of a 4,000-calorie intake,

**“We build
friendships
around healthy
food so people
start eating
healthier
naturally.”**

-Resenda Sykes

Ryan and his fellow neighbors demonstrate the desire to be full to the brim and over-satiated. Their conception of the word “eat” has acquired a broad ambiguity with respect to nutritional consumption. They do not eat to fuel, but instead eat for comfort. Much like calories, however, not all eating is created equal—diets that are high in cholesterol and fats are often low in iron, antioxidants and other vitamins.

Though this lack of portion control is spurred by the necessity to stretch their dollars (we are all guilty of reaching for seconds—or thirds—at any buffet), Ryan and his fellow housemates view food as a vehicle for satisfaction, not survival. With the high mortality rate of HIV and AIDS, many victims bear a lack of motivation to better a life that they feel has reached its expiration date. On your last day on earth, would you eat your favorite foods or a large bowl of brussels sprouts?

The 78 percent mortality rate of HIV and AIDS simply means that of the general population with the virus, 78 percent of deaths were directly caused by the disease. This does not say anything about life expectancy, which peaks at 72 years. Thus, the victims are not on their last limbs of life, and should take care of their bodies as such. Eating a diet rich in vegetables and fruits as part of an overall healthy diet may reduce risk for heart disease and type 2 diabetes and elevate one's mood. To the men and women at Doorways this means fewer prescriptions, fewer appointments, less reliance on medical technology, less hassle. In other words, more time to shuffle a deck of cards and play Spades or enjoy a trip to the St. Louis Zoo. But where does this health education begin, and how should it be structured?

Sykes and her Midtown Mamas, with a grant from St. Louis Catholic Charities, were able to make \$30 CSA boxes available for just \$3.50 to around 30 families in the neighborhood. These boxes included a variety of organic, in-season fruits and vegetables: spinach, romaine lettuce, tomatoes, eggplant, oranges, etc. Although these boxes increased accessibility to healthy food, they also increased confusion among recipients. Many were overwhelmed with the wide array of vegetables, unsure of how to utilize them.

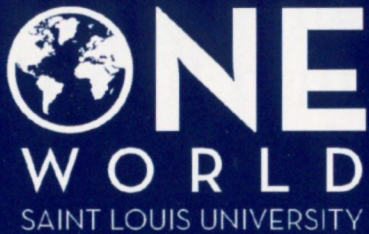
“We had to educate,” said Sykes. It was this thought that inspired the opening of their first storefront in 2016. Not only did CityGreens sell locally sourced food—fewer of which are grown further than Columbia, MO or Effingham, IL—at purchase prices, but they strive to create big lifestyle changes as a community.

“We build friendships around healthy food so people start eating healthier naturally,” Sykes said.

Upon entering their Manchester Avenue store, one immediately smells the aroma of fresh vegetables—peppers, potatoes, garlic, broccoli—being prepared with light spices. The Midtown Mamas demonstrate how to cook healthy meals, even prepare the infamously perplexing eggplant and acorn squash. Some notable favorites have been Ms. Bobbie's veggie wraps and Pauline's egg and potato breakfast casserole with smoked gouda cheese. By cooking with the low-cost ingredients available in-store, all that is required is a stove and a few kitchen appliances—all of which Doorways provides.

So, what are housing facilities like Doorways supposed to do? These homes have established communities—the men and women of each facility know each other by name, know each other's stories. The community is there, but the education is not. Unity and community do not have to be sacrificed in the name of healthy eating. Friendships are the basis for a community, and when a friendship is developed around healthy eating practices, then that friendship is both productive and enjoyable. Perhaps CityGreens can expand the borders of their storefront, bringing mobile markets and demonstrations to various low-income housing facilities throughout the St. Louis area. Or, the effort can begin with Doorways; by replacing Golden Corral outings with trips to St. Louis Metro Market, (a non-profit mobile farmer's market serving the St. Louis area food deserts by providing direct access to fresh, healthy, affordable produce); the Soulard Farmer's Market; or CityGreens.

But, as with all things, change begins with education.



OUR MISSION

We are already one, but imagine that we are not. OneWorld exists to rediscover that, while we are many in our cultures, religions and struggles, we are one in our common humanity. We yearn to remove the barriers of ignorance and injustice because the most basic and unchanging truth that unites us is the infinite value of the human person. OneWorld emphasizes this unity by raising awareness of social injustice, inspiring action and transforming our hearts, minds and society

THANK YOU TO OUR SPONSORS

The support of OneWorld's sponsors ensures that our organization will continue to grow and become a more sustainable and meaningful community project. To inquire about supporting us in 2016-2017, please email oneworldmagazine@gmail.com.

STUDENT
DEVELOPMENT

SAINT LOUIS UNIVERSITY

CENTER FOR
GLOBAL
CITIZENSHIP
SAINT LOUIS UNIVERSITY



CSC E

Center for Service
and Community Engagement
Serve • Learn • Engage



CONNECT WITH ONEWORLD



Visit our website at
<https://issuu.com/oneworldmagslu>



Like us on Facebook



Email us at
oneworldmagazine@gmail.com



Follow us on Twitter
[@live_OneWorld](https://twitter.com/live_OneWorld)